your

MEDICARE HANDBOOK 1997

HEALTH CARE FINANCING ADMINISTRATION

Message from the Secretary

For 31 years, Medicare has helped pay the medical bills for millions of older and disabled Americans, providing them with health insurance coverage and peace of mind. Over the years, Medicare has evolved into one of the world's best health insurance programs, delivering essential services and improving the quality of life for many of our most vulnerable citizens.

Today, Medicare provides health insurance for the large majority of older and disabled Americans, nearly 40 million people. Few programs, public or private, help so many in such an important way.

The Department of Health and Human and Services is dedicated to providing first-rate health care to members of the "Medicare family." Whether you are new to the Medicare program or not, we want to assure you of our commitment to keep Medicare working for you.

Donna E. Shalala
Secretary, Department of Health and Human Services

Your Medicare Handbook 1997 summarizes your Medicare benefits, rights and obligations and a list of organizations that you can contact if you need assistance with a Medicare-related matter.

President Clinton recently signed legislation that will result in changes to the Medicare program over the coming few years. As these changes become effective, the Health Care Financing Administration will provide you with additional information to explain how these changes affect your benefits, rights and obligations and the resources available to assist you.

For Sale by the Superintendent of Documents
U.S. Government Printing Office, Washington, D.C. 20402
Stock No. 017-060-00604-8; Telephone (202) 512-1800

TABLE OF CONTENTS

INTRODUCTION TO MEDICARE

Your Medicare Handbook is intended to provide you with the information you need in order to take full advantage of your Medicare benefits. On the following pages you will learn about:

- Who is eligible for Medicare.
- How to enroll in Medicare.
- What hospital and medical expenses are covered by Medicare.
- How much of the bill you are responsible for paying.
- How to protect your rights within the Medicare program.

You will also find information about managed care plans and Medicare supplemental (Medigap) insurance. And, in the back of the handbook, you will find a directory that lists the names and telephone numbers of organizations that can help you with Medicare-related issues.

If you are visually impaired, you may obtain a copy of this handbook in braille or audiotape by calling 1-800-638-6833. The audiotape may also be useful for people who have difficulty reading. This handbook is also available on the Internet. HCFA's Web site address is: **http://www.hcfa.gov**.

Medicare is administered by the Health Care Financing Administration (HCFA), a federal agency in the Department of Health and Human Services. The Social Security Administration (SSA) helps HCFA by enrolling people in Medicare and by collecting Medicare premiums. Various commercial insurance companies are under contract with HCFA to process and pay Medicare claims, and groups of doctors and other health care professionals have contracts to monitor the quality of care delivered to Medicare beneficiaries. And, of course, HCFA also forms partnerships with thousands of health care providers, including: hospitals, nursing homes, home health agencies, and doctors, as well as medical equipment suppliers, clinical laboratories, and managed care plans such as health maintenance organizations (HMOs). Together, this network of providers and other organizations combine to provide and pay for high-quality health care for Medicare's nearly 40 million beneficiaries.

This handbook explains the Medicare program, but it is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations and rulings.

WHAT IS MEDICARE?

Medicare is a national health insurance program for people 65 years of age and older, certain younger disabled people, and people with kidney failure. It is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

Both parts will be explained in more detail later. Basically, Part A helps pay for care in a hospital, a skilled nursing facility, and for home health and hospice care. Part B helps pay for doctors, outpatient hospital care, and various other medical services not covered by Part A.

Who's Eligible for Medicare?

Generally, you are eligible for Medicare if you or your spouse worked for at least 10 years in Medicare-covered employment, and you are 65 years old and a citizen or permanent resident of the United States. You might also qualify for coverage if you are a younger person with a disability or with chronic kidney disease.

Here are some simple guidelines. You can get Part A at age 65 without having to pay premiums if:

- You are already receiving retirement benefits from Social Security or the Railroad Retirement Board.
- You are eligible to receive Social Security or Rairoad Retirement benefits, but have not yet filed for them.
- You or your spouse had Medicare-covered government employment.

If you are under 65, you can get Part A without having to pay premiums if:

- You have received Social Security or Railroad Retirement Board disability benefits for 24 months.
- You are a kidney dialysis or kidney transplant patient.

While you do not have to pay a premium for Part A if you meet one of those conditions, you must pay for Part B if you want it. The Part B monthly premium in 1997 is $43.80. It is deducted from your Social Security, Railroad Retirement, or Civil Service Retirement check.

If you have questions about your eligibility for Medicare Part A or Part B, or if you want to apply for Medicare, call the Social Security Administration. The toll-free telephone number is: **1-800-772-1213.** The TTY/TDD number for the hearing and speech impaired is 1-800-325-0778. You can also get information about buying Part A, as well as Part B, if you do not qualify for premium-free Part A. The Part A premiums for 1997 appear near the bottom of the chart on page 16.

Medigap Insurance

Though Medicare covers many health care costs, you will still have to pay Medicare's coinsurance and deductibles. There are also many medical services that Medicare does not cover.

You may want to buy a Medicare supplemental insurance (Medigap) policy. Medigap is private insurance that is designed to help pay your Medicare cost-sharing amounts. There are 10 standard Medigap policies, and each offers a different combination of benefits.

The best time to buy a policy is during your Medigap open enrollment period. For a period of 6 months from the date you are first enrolled in Medicare Part B and are age 65 or older, you have a right to buy the Medigap policy of your choice. That is your open enrollment period.

You cannot be turned down or charged higher premiums because of poor health if you buy a policy during this period. Once your Medigap open enrollment period ends, you may not be able to buy the policy of your choice. You may have to accept whatever Medigap policy an insurance company is willing to sell you.

If you have Medicare Part B but are not yet 65, your 6-month Medigap open enrollment period begins when you turn 65. However, several states (Connecticut, Maine, Massachusetts, Minnesota, New Jersey, New York, Oklahoma, Oregon, Pennsylvania, Virginia, Washington, and Wisconsin) require at least a limited Medigap open enrollment period for Medicare beneficiaries under 65.

Your state insurance counseling office can answer questions about Medicare and other health insurance. The services are free. You can get help in deciding whether you need more insurance and, if so, what kind and how much to buy. A state-by-state listing of counseling office telephone numbers begins on page 29. Free copies of the *Guide to Health Insurance for People with Medicare* are also available from the counseling office.

Your state counseling office can also provide you with information about Medicare SELECT, another type of Medicare supplemental health insurance sold by insurance companies and HMOs throughout most of the country. Medicare SELECT is the same as standard Medigap insurance in nearly all respects. The only difference between Medicare SELECT and standard Medigap insurance is that each insurer has specific hospitals, and in some cases specific doctors, that you must use, except in an emergency, in order to be eligible for full benefits. Medicare SELECT policies generally have lower premiums than other Medigap policies because of this requirement. Medicare SELECT is explained in more detail in the *Guide to Health Insurance for People With Medicare*.

Suspected violations of the laws governing the marketing and sales of Medigap and other types of insurance policies should generally be reported to your state insurance department. The phone number for your state's insurance department is in the Blue Pages of your phone book. If you believe you have been a victim of Medigap fraud, you can also call the federal toll-free number for registering such complaints. The number is 1-800-638-6833, or TTY/TDD 1-800-820-1202 for the hearing or speech impaired.

Enrollment

Enrollment in Medicare is handled in two ways: either you are enrolled automatically or you have to apply. Here's how it works.

Automatic Enrollment: If you are not yet 65 and already getting Social Security or Railroad Retirement benefits, you do not have to apply for Medicare. You are enrolled automatically in both Part A and Part B and your Medicare card is mailed to you about 3 months before your 65th birthday. If you do not want Part B, follow the instructions that come with the card.

If you are disabled, you will be automatically enrolled in both Part A and Part B of Medicare beginning in your 25th month of disability. Your card will be mailed to you about 3 months before you are entitled to Medicare.

Applying for Medicare: You need to apply for Medicare if you are not receiving Social Security or Railroad Retirement Benefits three months before you turn 65, or if you require regular dialysis or kidney transplant. That's the beginning of your 7-month initial enrollment period. By applying early, you'll avoid a possible delay in the start of your Part B coverage. You apply by contacting any Social Security Administration office or, if you or your spouse worked for the railroad, the Railroad Retirement Board.

If you do not enroll during this 7-month period, you'll have to wait to enroll until the next general enrollment period. General enrollment periods are held January 1 to March 31 of each year, and Part B coverage starts the following July.

Don't put off enrolling. If you wait 12 or more months to sign up, your premiums generally will be higher. Part B premiums go up 10 percent for each 12 months that you could have enrolled but did not. The increase in the Part A premium (if you have to pay a premium) is 10 percent no matter how late you enroll for coverage.

Under certain circumstances, however, you can delay your Part B enrollment without having to pay higher premiums. If you are age 65 or over and have group health insurance based on your own or your spouse's current employment, or if you are disabled and have group health insurance based on your current employment or the current employment of any family member, you have a choice:

- You may enroll in Part B at any time while you are covered by the group health plan; or,
- You can enroll in Part B during the 8-month enrollment period that begins the month employment ends or the month you are no longer covered under the employer plan, whichever comes first.

If you enroll in Part B while covered by an employer plan or during the first full month when not covered by that plan, your coverage begins the first day of the month you enroll. You also have the option of delaying coverage until the first day of the following 3 months. If you enroll during any of the 7 remaining months of the special enrollment period, your coverage begins the month after you enroll.

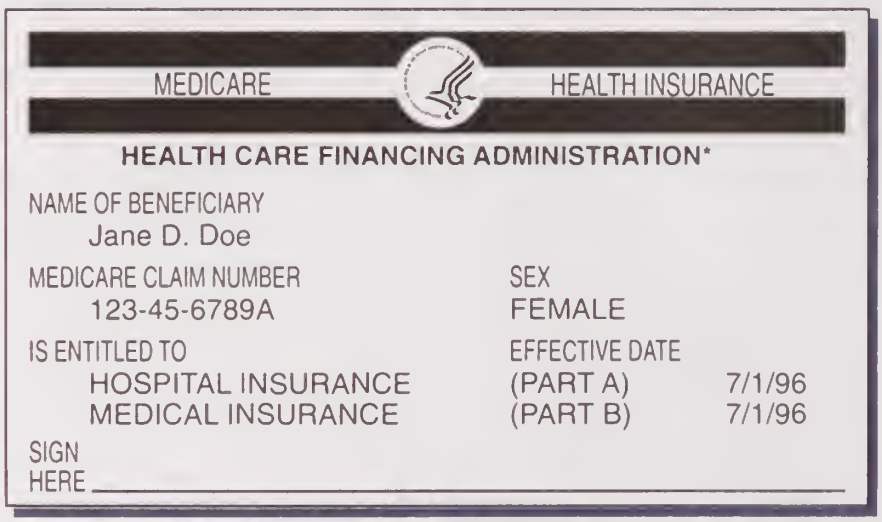
If you do not enroll by the end of the 8-month period, you'll have to wait until the next general enrollment period, which begins January 1 of the next year.

Even if you continue to work after you turn 65, you should sign up for Part A of Medicare. Part A may help pay some of the costs not covered by the employer plan. It may not, however, be advisable to sign up for Part B if you have health insurance through your employer. You would have to pay the monthly Part B premium, and the Part B benefits may be of limited value to you as long as the employer plan was the primary payer of your medical bills. Moreover, you would trigger your 6-month Medigap open enrollment period (see Medigap Insurance, page 4).

Your Medicare Card

Once enrolled, you'll receive a Medicare card imprinted with your name and Medicare claim number. It shows what coverage you have (Part A, Part B, or both) and the date your coverage started.

Show your card whenever you get medical care. This will assure that a claim for payment is sent to Medicare. Make sure to use your exact name and claim number. If you are married, your spouse will have his or her own card and claim number. Never let anyone else use your Medicare card, and keep the number as safe as you would a credit card number. Take your card with you when you travel, and have it handy when you call about a Medicare claim. If you lose your card, contact the Social Security Administration right away.


MEDICARE HEALTH INSURANCE

HEALTH CARE FINANCING ADMINISTRATION*

NAME OF BENEFICIARY
Jane D. Doe

MEDICARE CLAIM NUMBER
123-45-6789A

SEX
FEMALE

IS ENTITLED TO
HOSPITAL INSURANCE (PART A) 7/1/96
MEDICAL INSURANCE (PART B) 7/1/96

EFFECTIVE DATE

SIGN HERE _____

*Your card may say Social Security Act instead of Health Care Financing Administration.

MEDICARE CHOICES: FEE-FOR-SERVICE OR MANAGED CARE?

One important decision you may have to make is how you will receive your Medicare hospital and medical benefits. If you live in an area served by a managed care plan, you have a choice. You can receive your Medicare benefits either through the fee-for-service system or through a managed care plan such as a health maintenance organization (HMO).

If you choose fee-for-service, you choose from almost any doctor, hospital, or other health care provider. Generally, a fee is charged each time a service is used. Medicare pays its share of the bill. You are responsible for paying the balance.

In managed care, you usually get all of your care from the plan's doctors and health care providers, except in emergencies or when you are out of the plan's service area and have an urgent medical need. Depending on the plan, you may have to pay a monthly premium and a copayment each time you go to the doctor or use other services.

Regardless of whether you choose fee-for-service or managed care, you retain all of your Medicare benefits, protections, and appeal rights.

How Managed Care Works

Managed care works differently from fee-for-service. Managed care plans generally cover more services and have fewer out of pocket costs than fee-for-service. However, managed care plans also have different rules. Though committed to providing members with quality health care, managed care plans generally maintain some control over important health care decisions. They also can limit access to specialists and intervene in other medical decisions.

Managed care plans contract with Medicare to provide all of Medicare's benefits. In addition, managed care plans frequently offer additional benefits, such as help with prescription drugs—and there is little or no paperwork in a managed care plan.

You may have to pay a fixed monthly premium and a copayment each time a service is used. The premiums and copayments vary from plan to plan and can be changed each year. You also must continue to pay the Part B premium to Medicare. You do not pay Medicare's deductibles and coinsurance.

Usually, there are no other charges no matter how many times you visit the doctor, are hospitalized, or use other covered services. Your costs are, therefore, more predictable than under fee-for-service Medicare.

In addition to offering you all your Medicare benefits, many plans promote preventive health care by providing extra benefits such as eye examinations, hearing aids, routine physicals, and scheduled inoculations for little or no extra fee.

Each plan has its own network of hospitals, skilled nursing facilities, home health agencies, doctors and other professionals. Depending on how the plan is organized, services are usually provided either at one or more centrally located health facilities or in the private practice offices of the doctors and other health care professionals that are part of the plan. You generally must receive all covered care through the plan or from health care professionals to whom the plan refers you. In most cases, the plan will not pay if you go outside the plan without permission.

All managed care plans allow you to select a primary care doctor from those who are part of the plan. If you do not make a selection, one will be assigned to you. Your primary care doctor is responsible for managing your medical care, admitting you to a hospital and referring you to specialists. You are allowed to change your primary care doctor as long as you select another primary care doctor affiliated with the plan.

Types of Managed Care Plans

Before enrolling in a managed care plan, find out whether the plan has a "risk" or a "cost" contract with Medicare. There's an important difference.

Risk Plans: These plans have "lock-in" requirements. This means that you generally must receive all covered care through the plan or through referrals from the plan. If you receive services that are not authorized by the plan, neither the plan nor Medicare will pay. The only exceptions recognized by all Medicare-contracting plans are for emergency services, which you may receive anywhere in the United States, and for services you urgently need when you are temporarily out of the plan's service area.

A third exception offered by some risk plans is called the "point-of-service" (POS) option. Under the POS option, the plan permits you to receive certain services outside the plan's provider network and the plan will pay a percentage of the charges. In return for this flexibility, expect to pay at least 20 percent of the bill.

Cost Plans: These plans do not have "lock-in" requirements. If you enroll in a cost plan, you can either go to health care providers affiliated with the plan or go outside the plan. If you go outside the plan, the plan probably will not pay but Medicare will.

If you go outside of the plan, Medicare will pay its share of approved charges. You will be responsible for Medicare's coinsurance, deductibles and other charges, just as if you were receiving care under the fee-for-service system.

Because of this flexibility, a cost plan may be a good choice for you if you travel frequently, live in another state part of the year, or want to use a doctor who is not affiliated with a plan.

For information on how to join and leave a managed care plan, see page 24.

Who Pays First?

Medicare is not always the primary payer of your health care bills. Sometimes other insurers are required to pay before Medicare. Medicare will not make primary payment:

- If you are 65 or older and have group health insurance based on your own, or your spouse's, current employment.
- If you are disabled and under 65, and have group health insurance based on your own, or a family member's current employment, and the employer is covering at least 100 employees.
- For cases where no-fault insurance or liability insurance is available as the primary payer.
- For services related to a workers' compensation claim or injury that can be made under a workers' compensation law. (Note: Medicare will serve as primary payer if payment for treatment is not made under workers' compensation because the treatment was not authorized by that workers' compensation program, but is covered and judged medically necessary by Medicare.)
- For services that are covered under the Federal Black Lung program.

If you reject an employer's coverage while you or your family member is still employed, Medicare will be the primary payer. In this case, the employer cannot offer you coverage that supplements Medicare covered services.

If you have or can receive both Medicare and veteran benefits, you may choose to get treatment under either program. If you have this choice, remember that Medicare:

- Cannot pay for services received from Department of Veterans Affairs (DVA) hospitals or other DVA facilities, except in the case of certain emergency hospital services.
- Cannot pay if the DVA pays for DVA authorized services that you receive in a non-DVA hospital or from a non-DVA physician.

Hospitals, doctors, and other health care professionals must submit Medicare claims for you. They need to know if you are covered by other insurance that pays before Medicare, so they can submit a correct claim. If you have coverage that should pay before Medicare, you need to notify your doctor or other health professional at the time you are treated.

MEDICARE PART A COVERAGE

When all program requirements are met, Medicare Part A helps pay for:

- Care in a hospital.
- Care in a skilled nursing facility following a hospital stay.
- Home health care.
- Hospice care.

Benefit Periods

Coverage for care in hospitals and skilled nursing facilities is measured in "benefit periods." In each benefit period, you are limited as to the number of days Medicare will help pay for inpatient hospital and skilled nursing facility care. Once you exceed the limit, you are responsible for all charges for each additional day of care.

A benefit period begins the day you are admitted to a hospital. It ends when you have been out of a hospital or skilled nursing facility for 60 straight days, including the day of discharge. It also ends if you stay in a skilled nursing facility, without receiving skilled nursing care for 60 straight days.

Once you have ended one benefit period, a new benefit period begins and your hospital and skilled nursing facility benefits are renewed. There is no limit to the number of benefit periods you can have.

Inpatient Hospital Care

If you need inpatient hospital care, Medicare Part A helps pay for up to 90 days of medically necessary care in a Medicare-certified hospital in a benefit period. In addition, you have 60 lifetime reserve days that are discussed below.

During the first 60 days, Medicare pays all covered costs except for $760. That's the hospital deductible for 1997, and you are responsible for paying it. You only pay the deductible once during a benefit period no matter how many times you go to the hospital.

For the 61st through the 90th day in a benefit period, Medicare pays all covered costs except for coinsurance of $190 per day in 1997. You are responsible for paying the coinsurance.

Reserve Days: In the unlikely event that you are in the hospital for more than 90 days in a benefit period, you can use your "reserve days" to help pay the bill. You have a supply of 60 reserve days. Once a reserve day is used, it is not renewed. So if you use 10 reserve days, you'll have 50 left to use during the rest of your life.

When a reserve day is used, Medicare pays all covered costs except for daily coinsurance of $380 in 1997. Again, you are responsible for paying the coinsurance.

Covered Hospital Services: When you are in the hospital, Part A helps pay for a semiprivate room, meals, regular nursing services, rehabilitation services, drugs, medical supplies, laboratory tests, and X-rays. Coverage is also provided for use of the operating and recovery rooms, intensive care and coronary care units, and other medically necessary hospital services and supplies.

Hospital Services Not Covered: Medicare does not pay for personal convenience items such as a telephone or television in your room, for private duty nurses, or for any extra charges for a private room unless it is medically necessary.

Qualifying for Hospital Care: Medicare helps pay for inpatient hospital care when these four requirements are met:

1. A doctor prescribes inpatient hospital care for an illness or injury.
2. Your illness or injury requires care that can only be provided in a hospital.
3. The hospital participates in Medicare.
4. The hospital's Utilization Review Committee or a Peer Review Organization (PRO) did not disapprove your stay.

Important Message from Medicare: When you are admitted to the hospital for covered care, the hospital is required to give you a copy of a document called *An Important Message From Medicare.* If you do not get a copy, be sure to ask for one.

The message explains your rights as a Medicare hospital patient. It also tells you what to do if you think you are being discharged from the hospital too early or are notified that Medicare will no longer pay for your hospital care.

Advance Directive: Hospitals also must tell you about your right to prepare an advance directive. An advance directive is a written statement that explains what services you want, or do not want, if you ever become unable to communicate your wishes during a medical emergency.

Involve loved ones and your legal and religious advisers when preparing your advance directive. They can help ensure that your wishes are followed should you become incapacitated. Your doctor also should be consulted and asked to include the advance directive in your medical records. An advance directive is also called a "living will" or "durable power of attorney for health care."

Skilled nursing facilities, hospices, home health agencies, and HMOs serving Medicare beneficiaries also must give you information about advance directives.

Psychiatric Hospital Coverage: In addition to covering care in a general hospital, Part A helps pay for care in a Medicare-participating psychiatric hospital. Coverage for inpatient services is limited to a lifetime maximum of 190 days of care. Psychiatric care provided in a general hospital is not subject to the 190-day

limit. If you are a patient in a psychiatric hospital when you first become entitled to Medicare, there are additional limitations on the number of hospital days that Medicare will pay for.

Christian Science Sanatorium: Part A also helps pay for inpatient hospital and skilled nursing facility services provided by a participating Christian Science sanatorium. It must be operated or listed and certified by the First Church of Christ, Scientist, in Boston, to qualify for Medicare payment. Medicare will not pay for the practitioner.

Your Right to Appeal

You have a right to appeal many decisions concerning your Medicare benefits. You have this right whether you are part of Medicare fee-for service or you are enrolled in a Medicare managed care plan.

In Medicare fee-for-service, you are entitled to an appeal, in most cases, if you believe Medicare did not pay enough for services or if you believe Medicare has inappropriately denied payment for health care services you received. Any notice of a claim denial will include complete written instructions about how to appeal. For example, if you receive services covered under Part B of Medicare, your appeal rights will be detailed on the back of the Explanation of Medicare Part B Benefits (EOMB) form that is mailed to you. If you want further information on the fee-for-service appeals process, contact the carrier or intermediary that services your state.

In Medicare managed care, you may appeal if your plan denies a service, terminates a service too early, or refuses to pay for services that you believe should be covered. An appeal starts with a reconsideration by the managed care plan. An appeal may also go through a Medicare review and the full Medicare appeals process depending on the circumstances of your case. Additionally, you may be eligible for an expedited or fast decision (within 72 hours) if your health or ability to function could be seriously harmed by waiting for a standard decision. See the managed care plan's membership materials or contact your plan for details about your Medicare appeal rights.

Whether you are enrolled in fee-for-service or managed care, if you believe you are being discharged too soon from a hospital you have a right to immediate review by the Peer Review Organization (PRO). During the immediate review, you can stay in the hospital at no charge and the hospital cannot discharge you before the PRO reaches a decision.

Another source of information is your state's insurance counseling program. The phone number for that program is in the resource directory located in this book, starting on page 29.

Skilled Nursing Facility Care

If you need to go to a skilled nursing facility after being discharged from the hospital, Medicare can help pay for your care for up to 100 days in a benefit period. For Medicare to pay, you must meet the following five conditions:

1. You require daily skilled nursing or rehabilitation services that can only be provided in a skilled nursing facility.
2. You were in a hospital 3 days in a row, not counting the day of discharge, before entering the skilled nursing facility.
3. You are admitted to the facility within a short period of time (generally 30 days) after leaving the hospital.
4. The condition for which you are receiving skilled nursing care was treated in the hospital or arose while you were receiving care for a condition treated in the hospital.
5. A medical professional certifies that daily skilled nursing or rehabilitation care is necessary.

Part A pays the full cost of covered services for the first 20 days. All covered services for the next 80 days are paid by Medicare except for a daily coinsurance amount of $95 in 1997. You are responsible for paying the coinsurance. If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day.

What happens if you are discharged from a skilled nursing facility and later must be readmitted? If you are readmitted within 30 days, Medicare will resume paying for your care until you have used up your 100 days of coverage. The care must be for a condition treated during your previous stay.

If you have been out of the skilled nursing facility 60 or more days and the benefit period has ended, another 3-day hospital stay is required before your skilled nursing facility care benefits are renewed.

A skilled nursing facility is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. The care must be either performed by or provided under the supervision of licensed nursing personnel or professional therapists.

Not all nursing homes are skilled nursing facilities. Many nursing homes primarily offer custodial care such as help in eating, bathing, taking medicine, and toileting. Medicare does not cover custodial care if that is the only care you need.

If you're in doubt about whether your stay in a skilled nursing facility will be covered by Medicare, ask your doctor or someone in the facility's business office. Keep in mind that a skilled nursing facility cannot require you to pay a cash deposit as a condition of admission unless it is clear that your care will not be covered by Medicare.

It is important to know that Medicare pays only a small fraction of the nation's nursing home bills. Most nursing home bills are paid for with personal funds, purchased long-term care insurance, and by Medicaid, a program for people with low incomes. For more information on paying nursing home bills, contact your state's insurance counseling program. You will find the phone number in the resource directory of this book.

Blood Coverage

You may need blood as part of a covered inpatient stay in a hospital or a skilled nursing facility—whole blood, units of packed red blood cells, or blood components. If so, Medicare will help pay the costs, including the cost of processing and administering it.

You must either pay for or replace the first three pints of blood, the annual blood deductible. You can replace the blood you use yourself or have another person donate on your behalf.

Both Part A and Part B of Medicare cover blood, and if you meet the three-pint blood deductible under one part you do not have to meet it under the other part.

Home Health Care

If you are confined to your home and require skilled care for an injury or illness, Medicare can pay for care provided in your home by a home health agency. A prior stay in the hospital is not required to qualify for home health care, and you do not have to pay a deductible for home health services.

Medicare Part A (or Part B if you do not have Part A) pays the entire bill for covered services for as long as they are medically reasonable and necessary. If you meet the eligibility requirements for the home health care benefit, Medicare covers part-time or intermittent skilled nursing services, home health aide service, or physical, speech-language, and occupational therapy.

Besides paying for health care services, the home health benefit also covers the full cost of some medical supplies when billed by the home health agency and 80 percent of the approved amount for durable medical equipment, such as wheelchairs, hospital beds, oxygen supplies, and walkers.

Qualifying for Home Health Care: Medicare pays for home health care when these four conditions are met:

1. You require intermittent skilled nursing care, physical therapy, or speech-language pathology.
2. You are confined to your home.
3. Your doctor determines that you need home health care and sets up a plan for you to receive care at home.
4. The home health agency providing the care participates in Medicare.

You can find a Medicare-approved home health agency by asking your doctor or your hospital discharge planner.

Hospice Care

Another benefit available under Part A is hospice care if you become terminally ill. You can elect to receive hospice care rather than regular Medicare benefits for the management of your illness.

Hospice care may be provided by either a private organization or a public agency. With hospice care, the emphasis is on providing comfort and relief from pain. While the Medicare hospice benefit primarily provides for care at home, it can help pay for inpatient care as well as for a variety of services not usually covered by Medicare, including homemaker services, counseling, and certain prescription drugs.

Medicare pays nearly the entire bill for hospice care. There can be a copayment of up to $5 for each drug prescription and about $5 per day for inpatient respite care. Respite care is intended to give temporary relief to the person or persons who regularly assist with home care.

Qualifying for Hospice Care: Medicare pays for hospice care when these three conditions are met:

1. Your doctor and the hospice's doctor certify that you are terminally ill.
2. You choose to receive hospice care instead of the standard Medicare benefits for the illness.
3. The care is provided by a Medicare-participating hospice program.

If you elect hospice care and later require treatment for a condition other than the terminal illness, you can receive Medicare's standard benefits. When standard benefits are used, you must pay any required deductibles and coinsurance.

Part A Claims

When you receive services covered by Part A, you do not file a claim for payment. In fact, you seldom, if ever, have to get involved in the processing of a Part A claim.

The hospital, skilled nursing facility, or other provider from whom you received services files the claim for you. It is sent to a private insurance organization called a "Medicare intermediary." The intermediary has a contract with the federal government to handle Part A claims.

The intermediary will send you a *Benefits Notice* showing what was billed, Medicare's portion of the bill, and what you are responsible for paying. All questions about charges and payments should be directed to the intermediary. The intermediary's address and telephone number appear on the notice.

MEDICARE HOSPITAL INSURANCE (PART A) COVERED SERVICES FOR 1997

Services	Benefit	Medicare Pays	You Pay
HOSPITALIZATION Semiprivate room and board, general nursing and other hospital services and supplies. (Medicare payments based on benefit periods; see pg. 10.)	First 60 days	All but $760	$760
	61st to 90th day	All but $190 a day	$190 a day
	91st to 150th day*	All but $380 a day	$380 a day
	Beyond 150 days	Nothing	All costs
SKILLED NURSING FACILITY CARE Semiprivate room and board, skilled nursing and rehabilitative services, and other services and supplies. **	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $95 a day	Up to $95 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies, and other services.	Unlimited as long as you meet Medicare requirements for home health care benefits.	100% of approved amount for services; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Pain relief, symptom management, and support services for the terminally ill.	For as long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD When furnished by a hospital or skilled nursing facility during a covered stay.	Unlimited during a benefit period if medically necessary.	All but first 3 pints per calendar year.	For first 3 pints.***

* 60 reserve days may be used only once.

** Neither Medicare nor Medigap insurance will pay for most nursing home care.

*** To the extent the three pints of blood are paid for or replaced under one part of Medicare during the calendar year, they do not have to be paid for or replaced under the other part.

1997 Part A monthly premium: $311 with fewer than 30 quarters of Medicare-covered employment; $187 with 30 or more quarters, but fewer than 40 quarters of covered employment. Most beneficiaries do not have to pay a premium for Part A.

MEDICARE MEDICAL INSURANCE (PART B) COVERED SERVICES FOR 1997

Services	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSES Physician's services, inpatient and outpatient medical and surgical services and supplies, physical, occupational and speech therapy, diagnostic tests, and durable medical equipment.	Unlimited services if medically necessary, except for the services of independent physical and occupational therapists.	80% of approved amount (after $100 deductible); 50% of approved amount for most outpatient mental health services; up to $720 a year each for independent physical and occupational therapy.	$100 deductible;* 20% of approved amount after deductible; charges above approved amount;** 50% for most outpatient mental health services; 20% of first $900 for each independent physical and occupational therapy and all charges thereafter each year.
CLINICAL LABORATORY SERVICES Blood tests, urinalysis, and more.	Unlimited if medically necessary.	Generally 100% of approved amount.	Nothing for services.
HOME HEALTH CARE*** Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services.	Unlimited as long as you meet Medicare requirements.	100% of approved amount for services; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of amount approved for durable medical equipment.
OUTPATIENT HOSPITAL SERVICES Services for the diagnosis or treatment of an illness or injury.	Unlimited if medically necessary.	Medicare payment to hospital based on hospital costs.	20% of whatever the hospital charges (after $100 deductible).*
BLOOD	Unlimited if medically necessary.	80% of approved amount (after $100 deductible and starting with 4th pint).	First 3 pints plus 20% of approved amount for additional pints (after $100 deductible).****

* You pay the $100 Part B deductible only once each year.

** Federal law limits charges for physician services (see page 20)

*** Part B pays for home health care only if you do not have Part A of Medicare.

**** To the extent any of the three pints of blood are paid for or replaced under one part of Medicare during the calendar year, they do not have to be paid for or replaced under the other part.

1997 Part B monthly premium: $43.80 (premium may be higher if you enroll late).

MEDICARE PART B COVERAGE

Medicare Part B pays for a wide range of medical services and supplies, but perhaps most important, it helps pay doctor bills.

The medically necessary services of a doctor are covered no matter where you receive them, whether at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital.

Benefit Limits

Some Part B benefits have special requirements, and some are more strictly limited than others. Pap smears, for example, are generally covered once every 3 years, mammograms every 24 months, and therapeutic shoes once a year for people who have severe diabetic foot disease.

You can receive services from an independent, Medicare-approved physical or occupational therapist. But the maximum Medicare will pay for each type of therapy in 1997 is $720.

Durable Medical Equipment: Wheelchairs and other durable medical equipment are covered only when prescribed by a doctor for use at home and when provided by a supplier approved by Medicare. You can find out what equipment is covered, and whether a supplier is approved, by calling Medicare's durable medical equipment (DME) regional carrier for your area. A state-by-state listing of DME carriers begins on page 29.

Part B also helps pay for:

- Outpatient hospital services.
- X-rays and laboratory tests.
- Ambulance transportation.
- Breast prostheses following a mastectomy.
- Physical and occupational therapy.
- Speech-language pathology services.
- Home health care, if you do not have Part A of Medicare.
- Blood, after the first three pints.
- Flu, pneumonia, and hepatitis B shots.
- Screening Pap smears to detect cervical cancer.
- Mammograms to screen for breast cancer.
- Outpatient mental health services.
- The services of practitioners such as clinical psychologists and clinical social workers
- Artificial limbs and eyes.
- One pair of eyeglasses after cataract surgery.
- Arm, leg, back, and neck braces.
- Durable medical equipment, including wheelchairs, walkers, hospital beds, and oxygen equipment prescribed for home use by a doctor.
- Kidney dialysis and kidney transplants. Under limited circumstances, heart, lung, and liver transplants in a Medicare-approved facility.
- Medical supplies and items such as ostomy bags, surgical dressings, splints, and casts.

Ambulance Services: The ambulance benefit is also strictly limited. Medicare will help pay for the service only if:

1. The ambulance, equipment, and personnel meet Medicare requirements, *and*;
2. Transportation in any other vehicle could endanger your health.

Coverage is generally restricted to transportation between your home and a hospital, your home and a skilled nursing facility, or a hospital and a skilled nursing facility.

What's Not Covered: Many medical services and items are not covered by Medicare. They include, but are not limited to, routine physicals, most dental care, dentures, routine foot care, hearing aids, and most prescription drugs. Eyeglasses are covered only if you need corrective lenses after a cataract operation.

What You Pay

When you use your Part B benefits, you are responsible for paying the first $100 of the charges approved by Medicare. This is called the Part B annual deductible.

After the deductible is met, Medicare pays 80 percent of the Medicare-approved amount for most services. You are responsible for the remaining 20 percent. This is called Part B coinsurance.

Sometimes your share of the bill is more than 20 percent of the Medicare-approved amount. If you receive outpatient services at a hospital, you are responsible for paying 20 percent of whatever the hospital charges, not 20 percent of a Medicare-approved amount. For some outpatient mental health services, your share is 50 percent of the Medicare-approved amount.

Besides having to pay Medicare's deductibles and coinsurance, you are responsible for all charges for services and supplies you receive that are not covered by Medicare.

What Is Assignment?

Always ask your doctors and medical suppliers whether they accept assignment. If they do, they will accept the amount Medicare approves for a particular service or supply and will not charge you more than the deductible and 20 percent coinsurance. That can mean savings for you.

Here's how. Let's suppose you go to a doctor who accepts assignment and that you have already paid the $100 Part B deductible for the year. Let's also assume that the Medicare-approved amount for the service you receive is $100.

Medicare would pay 80 percent of the $100 approved amount, or $80. You would be responsible for the other 20 percent, or $20. Medicare would pay its share of the bill directly to the doctor after the doctor filed your claim. The doctor could ask you to pay the $20 immediately but could not ask for more.

Here's what could happen if the doctor did not accept assignment. The doctor could charge $115, which is the $100 Medicare-approved amount plus the extra 15 percent that doctors who do not accept assignment are permitted to charge.

Medicare would pay 80 percent of $100, or $80 and you would be responsible for the remaining $35. But for doctors who do not accept Medicare assignment, Medicare will pay only its share of the bill, and the doctor could ask you to pay the $115 immediately. Medicare would send you a check for $80 after the doctor filed your claim.

Limiting Charge: Be aware that federal law prohibits a doctor who does not accept assignment from charging more than 15 percent above Medicare's approved amount. Any overcharges must be refunded. The following states offer stricter guidelines on limiting charges: Connecticut, Massachusetts, Minnesota, New York, Ohio, Pennsylvania, Rhode Island, and Vermont. If you live in one of these states, check with your state's insurance counseling program for details. You will find the phone number in the resource directory at the back of this book.

Other Charge Limits: Doctors who do not accept assignment for elective surgery are required to give you a written estimate of your costs before the surgery if the total charge will be $500 or more. If you are not given a written estimate, you are entitled to a refund of any amount you paid in excess of the Medicare-approved amount for the surgery performed.

Additionally, any doctor who does not participate in Medicare and who provides you with a service that he or she knows or has reason to believe Medicare will determine to be medically unnecessary must tell you that in writing before performing the service. This is because Medicare will not pay for services it judges to be medically unnecessary. If written notice is not given, and you did not know that Medicare would not pay, you cannot be held liable to pay for that service. However, if you did receive written notice and signed an agreement to pay for the service, you will be held liable to pay.

Participating Doctors and Suppliers: To avoid excess charges, go to doctors and medical suppliers who accept assignment. Some do on a case-by-case basis. Others sign agreements to accept assignment of all Medicare claims. They are called participating doctors and suppliers. You can get the names, addresses, and telephone numbers of participating doctors and suppliers by calling your Medicare carrier. You will find the phone number for your state's carrier in the resource directory of this book.

Part B Claims

Carriers are private insurance companies that contract with the federal government to process Medicare claims and make payments for services and supplies covered by Part B.

Every time you go to the doctor for a service covered by Medicare, the doctor is required by law to send the claim for payment to the

carrier for the area where the service was provided. After processing your claim, the carrier usually will send you a notice about your benefits. It shows what was billed, the amount Medicare approved, and what you owe. It also tells you how to file an appeal if you disagree with a payment decision. Contact the carrier with any questions about a Part B claim. The carrier's name and telephone number are printed on the benefit notice. A state-by-state listing of Medicare carriers begins on page 29.

If you get Medicare under the Railroad Retirement system, your claims are processed by the United Health Care office that serves your region. You can get the telephone number from any Railroad Retirement Board office.

Getting A Second Opinion

Sometimes your doctor may recommend surgery for the treatment of a medical problem. In some cases, surgery is unavoidable. But, there is increasing evidence that many conditions can be treated equally well without surgery. Because even minor surgery involves some risk, you may want to get the opinion of another doctor before making a decision.

Medicare pays the same way for a second opinion as it pays for other doctor services as long as you are seeking advice for the treatment of a medical condition covered by Medicare. If the first two opinions contradict each other, Medicare will help pay for a third opinion. You can ask your own doctor to refer you to another doctor for a second opinion. Or, you can call your Medicare carrier and ask for the names and phone numbers of doctors in your area who provide second opinions.

Health Care Outside The United States

In general, Medicare will not pay for health care obtained outside the United States and its territories. Medicare can pay for inpatient hospital services that you get in Canada or Mexico if:

★ You are in the United States when a medical emergency occurs and the Canadian or Mexican hospital is closer than the nearest U.S. hospital that can treat the emergency.

★ You are traveling through Canada without unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency.

★ You live in the United States and a Canadian or Mexican hospital is closer to your home than the nearest U.S. hospital that can treat your medical condition, regardless of whether an emergency exists.

Medicare also pays for doctor and ambulance services furnished in Canada or Mexico in connection with a covered inpatient hospital stay. When in doubt about whether Medicare will pay for health care services, ask your Medicare carrier.

MEDICARE AND OTHER HEALTH CARE PROVIDERS

Special Health Care Facilities

Besides helping to pay for care in a hospital or skilled nursing facility, Medicare covers a variety of services provided at special types of health care facilities.

Ambulatory Surgical Center: Part B helps pay for certain types of surgery performed at a Medicare-approved ambulatory surgical center. This type of surgery does not require a hospital stay.

Rural Health Clinic: Various services provided at rural health clinics are also covered by Medicare. These clinics serve areas where few people live. Medicare pays for services provided by the doctors, nurse practitioners, doctor assistants, nurse midwives, clinical psychologists, and social workers that are part of the clinic.

Comprehensive Outpatient Rehabilitation Facility: Part B pays for services provided at a comprehensive outpatient rehabilitation facility if they were prescribed by a doctor and the facility participates in Medicare.

Community Mental Health Center: Under certain conditions, Part B helps pay for partial hospitalization programs provided by community mental health centers or hospital outpatient departments. These specialized programs provide acute mental health care to outpatients. Your doctor must order the care, and the program must participate in Medicare.

Federally Qualified Health Center: A full range of services can be obtained at federally qualified health centers. These facilities are mainly community health centers, Indian health clinics, migrant worker health centers, and health centers for the homeless. They are generally located in inner-city and rural areas, and they are open to all Medicare beneficiaries.

Certified Medical Laboratory: Laboratory clinical diagnostic tests are covered when provided by a certified medical laboratory that participates in Medicare. The laboratory must accept assignment of your Medicare claim and cannot bill you. Part B pays all charges. (In Maryland only, you can be billed for 20 percent coinsurance for hospital outpatient tests.)

Other Health Professionals

Most of the doctor services covered by Medicare must be provided by either a doctor of medicine or a doctor of osteopathy. Medicare generally does not pay for the routine services provided by optometrists, podiatrists, dentists, or chiropractors. However, in some cases, Medicare will pay for some of the services provided by these professionals. Since the rules are complicated, you should check with your Medicare carrier to see what services are covered.

The carrier can also tell you whether Medicare will pay for services provided by a medical professional who is not a doctor. In some cases, Medicare covers the services of certified registered nurse anesthetists, clinical nurse specialists, certified midwives, nurse practitioners, physical and occupational therapists, physician assistants, clinical social workers, and clinical psychologists. The coverage is limited, so call your Medicare carrier to find out whether Medicare will pay for the kind of service you need.

Preventive Care Under Medicare

Medicare helps pay for a limited number of preventive services.

Medicare helps pay for flu and pneumonia shots. The flu shot is given each year before flu season, generally between October and December. The pneumonia shot can be given at any time. Most people need to get the pneumonia shot only once. Your doctor can tell you if you have any health conditions that will make revaccination necessary at a later date.

Flu and pneumonia shots are important in preventing illnesses that could lead to hospitalization or death. If you are not sure if you had a pneumonia shot, ask your doctor. You can get the pneumonia shot when you get your next flu shot.

Medicare also helps pay for the hepatitis B vaccine if you are at high risk of contracting hepatitis B. The shot must be ordered by your doctor.

Medicare helps pay for X-ray screenings for the detection of breast cancer and for Pap smears to detect cervical cancer. Women 65 or older can use the breast cancer screening benefit every 24 months, while women at high risk for breast cancer can use the benefit more frequently.

JOINING AND LEAVING A MANAGED CARE PLAN

Enrolling in a Plan

Most Medicare beneficiaries can enroll in a managed care plan. To enroll:

1. You must have Medicare Part B and continue paying Part B premiums.
2. You must live in the plan's service area.
3. You cannot be receiving care in a Medicare-certified hospice at the time of enrollment.
4. You cannot have permanent kidney failure at the time of enrollment.

The names of the plans in your area are available by calling your state insurance counseling office. (See state-by-state listing beginning on page 29.) Insurance counselors will give you information about the plans in your state to help you decide whether managed care is right for you.

All plans that have contracts with Medicare must have an advertised open enrollment period of at least 30 days once a year. Plans must enroll Medicare beneficiaries in the order of application. You cannot be rejected because of poor health.

If your area is served by more than one plan, compare the doctors' qualifications, facilities, premiums, copayments, and benefits to determine which plan best suits your needs at a price you can afford. Determine whether the plan's providers are in a location convenient to you and whether transportation is available at all hours to get you to them.

Carefully weigh the advantages and disadvantages of plan membership if you travel a lot or live part of the year in another state. Plans must provide coverage for the first 90 days when you travel.

Also keep in mind that if you enroll in a plan and later move out of the plan's service area, you will have to disenroll and either return to fee-for-service Medicare or enroll in a plan that serves your new location. Because each plan is different, your benefits and premiums probably will not be exactly the same if you enroll in another plan.

Leaving a Plan

You can stay in a managed care plan as long as it has a Medicare contract or you can leave at any time to join another plan or to return to fee-for-service Medicare.

To end your enrollment, send a signed request to the plan or to your local Social Security Administration office or, if appropriate, the Railroad Retirement Board. You will return to fee-for-service Medicare the first day of the next month after the plan receives your request to disenroll.

Changing from one managed care plan to another is simple if both plans have a Medicare contract. When you enroll in a new plan you are automatically disenrolled from the first plan.

Medigap insurance is another matter that you should consider if you are thinking about

enrolling in a plan or if you are already in a plan and are thinking about disenrolling.

If you have a Medigap policy and decide to join a managed care plan, you may want to keep your Medigap policy for a short amount of time while deciding if you like managed care. You generally do not need a Medigap policy if you are in a managed care plan, but keeping your Medigap policy could help you if you decide to leave managed care and go back to fee-for-service Medicare. If you had a Medigap policy but dropped it when you joined a managed care plan, you may not be able to get the same Medigap policy back, especially if you have a health problem.

Protection from Discrimination

The Department of Health and Human Services has an Office for Civil Rights that is responsible for enforcing laws that ban discrimination on the basis of race, color, sex, national origin, disability, or age. Every facility or agency that participates in Medicare must comply with the law. If you believe that you have been discriminated against based on any of these categories, contact one of the offices listed below.

Use this table to find the Office for Civil Rights for your state.

State	Telephone	TTY/TDD
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	(617) 565-1340	(617) 565-1343
New York, New Jersey, Puerto Rico, Virgin Islands	(212) 264-3313	(212) 264-2355
Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	(215) 596-1262	(215) 596-5195
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	(404) 331-2779	(404) 331-2867
Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	(312) 886-2359	(312) 353-5693
Arkansas, Louisiana, New Mexico, Oklahoma, Texas	(214) 767-4056	(214) 767-8940
Iowa, Kansas, Missouri, Nebraska	(816) 426-7278	(816) 426-7065
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	(303) 844-2024	(303) 844-3439
American Samoa, Arizona, California, Guam, Hawaii, Nevada	(415) 437-8310	(415) 437-8311
Alaska, Idaho, Oregon, Washington	(206) 615-2290	(206) 615-2296

PROGRAMS THAT HELP LOW-INCOME BENEFICIARIES

If you are a Medicare beneficiary with a very low income and few assets, you might qualify for state assistance in paying your health care costs. There are two programs that can help. One is called the "Qualified Medicare Beneficiary" (QMB) program and the other is called the "Specified Low-Income Medicare Beneficiary" (SLMB) program.

The QMB program pays Medicare's premiums, deductibles, and coinsurance for entitled older and disabled people who are qualified for Medicare Part A. If you do not have Part A or do not know if you are entitled, check with your local Social Security office, or call 1-800-772-1213. The TTY/TDD number for the hearing and speech impaired is 1-800-325-0778.

To be entitled to QMB, your income must be at or below the national poverty level and your financial resources (bank accounts, stocks, bonds, etc.) cannot be more than $4,000 for one person, or $6,000 for a couple. Some property, including the home you live in, one car, burial plots, and life insurance are usually not counted as resources.

The QMB monthly income limits for 1997 in the United States, for all States except Alaska and Hawaii, are:

- $678 for an individual
- $905 for a couple.

For Alaska, the QMB limits are $843 for an individual and $1126 for a couple.

For Hawaii, the QMB limits are $776 for an individual and $1037 for a couple.

If your income is too high to qualify for QMB, you may be able to get help under the SLMB program. SLMB pays your Medicare Part B premium, but does not help with Part A. To qualify for SLMB, you must be entitled to Medicare Part A and meet QMB requirements. The difference is that SLMB entitlement is set at 20 percent above the national poverty level.

The SLMB monthly income limits for 1997 in the United States, for all states except Alaska and Hawaii, are:

- $809 for an individual
- $1081 for a couple.

For Alaska, the SLMB limits are $1007 for an individual and $1347 for a couple. For Hawaii, the SLMB limits are $927 for an individual and $1240 for a couple.

If you already have Medicare Part A and think you qualify for either QMB or SLMB assistance, you must file an application for Medicaid at your state's local medical assistance or social services office. Check the Blue Pages of your phone book to find the address and phone number of your local office.

Your state's insurance counseling program can also help, their phone number is in the resource directory in the back of this book.

BENEFICIARY RESOURCE DIRECTORY

This directory provides a state-by-state listing of Medicare carriers, Peer Review Organizations (PROs), Medicare durable medical equipment regional carriers, state insurance counseling offices, and numbers for the Health Care Financing Administration's 10 regional offices. An explanation of the assistance available from each of these organizations follows.

Medicare Carriers can answer questions about Medicare coverage and Medicare Part B claims. The toll-free 800 numbers listed, in many cases, can be used only in the states where the carriers are located. Out-of-state callers may use a carrier's commercial number, if one is listed.

Peer Review Organizations (PROs) are groups of practicing doctors and other health care professionals paid by the federal government to monitor the quality of care provided to Medicare patients by hospitals, skilled nursing facilities, home health agencies, managed care plans, and ambulatory surgical centers. If the quality of care you received from one of these facilities was unsatisfactory or you think you are being discharged from the hospital too early, you may file a written complaint with your state's PRO.

If you need help in preparing the complaint, the PRO will take the information from you over the telephone and write the complaint for you.

Durable Medical Equipment Regional Carriers can tell you what durable medical equipment (wheelchairs, hospital beds, prosthetics, etc.) is covered by Medicare and what the Medicare-approved amount is for a particular piece of equipment. The regional carrier can also identify durable medical equipment suppliers in your area who are approved by Medicare. If you have a complaint about a supplier or suspect that you have been improperly billed for durable medical equipment or otherwise defrauded, contact your durable medical equipment regional carrier.

State Insurance Counseling and Assistance Programs can provide you with general information about Medicare, Medicaid, managed care plans, and the various types of health insurance available to supplement Medicare, including Medigap and long-term care insurance. Counselors can also help you with questions about your medical bills, insurance claims, and Medicare benefit explanation forms. The services are free.

The Social Security Administration can answer questions about Medicare enrollment, entitlement, and premiums, and help you replace a lost Medicare card. Call **1-800-772-1213** (TTY/TDD 1-800-325-0778).

Health Care Financing Administration Regional Offices can answer questions about Medicare policy and help resolve Medicare-related problems involving a Medicare carrier, PRO, or other organization that is under contract to the federal government to serve Medicare beneficiaries. These offices can also give you the names of managed care plans that serve your area. For general information about Medicare or for help with a specific issue, you should first contact the organization listed herein that provides the services you need or handles the type of issues or problems that you want help with. If you still are not satisfied, call the HCFA regional office that serves your state. The service areas and telephone numbers appear on page 40.

Medicare Carriers	Insurance Counseling and Information	Peer Review Organizations (PROs)	Durable Medical Equipment Regional Carriers
ALABAMA Blue Cross/Blue Shield of Alabama 1-800-292-8855 or (205) 988-2244	Insurance-Information Counseling and Assistance Program 1-800-243-5463	Alabama Quality Assurance Foundation 1-800-760-3540	Palmetto Government Benefits Administrators 1-800-213-5452 Spanish: 1-800-213-5446
ALASKA Medicare Part B 1-800-444-4606	Insurance Counseling Program 1-800-478-6065	PRO-WEST 1-800-445-6941 in Anchorage: (503) 562-2252	CIGNA Medicare 1-800-899-7095
ARIZONA Medicare Part B 1-800-444-4606	Medicare Information Referral 1-800-432-4040	Health Services Advisory Group, Inc. 1-800-626-1577	CIGNA Medicare 1-800-899-7095
ARKANSAS Blue Cross/Blue Shield 1-800-482-5525 or (501) 378-2320	Senior Insurance Network 1-800-852-5494	Arkansas Foundation for Medical Care, Inc. 1-800-272-5528	Palmetto Government Benefits Administrators 1-800-213-5452
CALIFORNIA Transamerica Occidental Life Ins. Co. Counties of Los Angeles, Orange, San Diego, Ventura, Imperial, San Luis Obispo, and Santa Barbara: 1-800-675-2266 or (213) 748-2311 Rest of state: National Heritage Insurance Co. 1-800-952-8627 or (916) 743-1583	Health Insurance Counseling and Advocacy Program 1-800-434-0222	California Medical Review, Inc. 1-800-841-1602 or (415) 882-5800	CIGNA Medicare 1-800-899-7095

Medicare Carriers	Insurance Counseling and Information	Peer Review Organizations (PROs)	Durable Medical Equipment Regional Carriers
COLORADO Blue Shield of North Dakota 1-800-322-6681 or (303) 831-2661	Senior Health Insurance Assistance Program 1-800-544-9181	Colorado Foundation for Medical Care 1-800-727-7086 or (303) 695-3333	Palmetto Government Benefits Administrators 1-800-213-5452
CONNECTICUT MetraHealth Insurance Company 1-800-982-6819 Meriden: (203) 237-8592	Programs for Health Insurance Assistance, Outreach, Information and Referral (CHOICES) 1-800-994-9422	Connecticut Peer Review Organization, Inc. 1-800-553-7590 or (860) 632-2008	United Health Care Insurance Co. 1-800-842-2052
DELAWARE Xact Medicare Services 1-800-851-3535	ElderInfo 1-800-336-9500	West Virginia Medical Institute, Inc. 1-800-642-8686 ext. 266 in Wilmington: (302) 655-3077	United Health Care Insurance Co. 1-800-842-2052
DISTRICT OF COLUMBIA Xact Medicare Services 1-800-233-1124	Health Insurance Counseling Project (202) 676-3900	Delmarva Foundation for Medical Care, Inc. DC: 1-800-999-3362 MD: 1-800-492-5811	AdminaStar Federal, Inc. 1-800-270-2313
FLORIDA Blue Cross/Blue Shield of Florida 1-800-333-7586 or (904) 355-3680	Serving Health Insurance Needs of Elders 1-800-963-5337	Florida Medical Quality Assurance, Inc. 1-800-844-0795 or (813) 354-9111	Palmetto Government Benefits Administrators 1-800-213-5452
GEORGIA Cahaba Government Benefits Administrators 1-800-727-0827 or (912) 920-2412	Health Insurance Counseling and Referral for the Aging 1-800-669-8387	Georgia Medical Care Foundation 1-800-982-0411 or (404) 982-0411	Palmetto Government Benefits Administrators 1-800-213-5452

Medicare Carriers	Insurance Counseling and Information	Peer Review Organizations (PROs)	Durable Medical Equipment Regional Carriers
HAWAII Medicare Part B 1-800-444-4606	SAGE PLUS (808) 586-0100	Mountain Pacific Quality Health Foundation 1-800-524-6550 in Oahu: (808) 545-2550	CIGNA Medicare 1-800-899-7095
IDAHO Medicare Part B 1-800-627-2782 or (615) 244-5650	Senior Health Insurance Benefits Advisors 1-800-247-4422	PRO-WEST 1-800-445-6941 or (208) 343-4617	CIGNA Medicare 1-800-899-7095
ILLINOIS Claims/Health Care Service Corp. 1-800-642-6930 or (312) 938-8000 TTY/TDD: 1-800-535-6152	Senior Health Insurance Program 1-800-548-9034	Illinois Foundation for Medical Care 1-800-647-8089	AdminaStar Federal Inc. 1-800-270-2313
INDIANA AdminaStar Federal 1-800-622-4792 or (317) 842-4151	Senior Health Insurance Information Program 1-800-452-4800	Health Care Excel, Inc. 1-800-288-1499	AdminaStar Federal 1-800-270-2313
IOWA IASD Health Services Corporation Blue Cross/Blue Shield of Iowa 1-800-532-1285 or (515) 245-4785	Senior Health Insurance Information Program 1-800-351-4664	Iowa Foundation for Medical Care 1-800-752-7014 or (515) 223-2900	CIGNA Medicare 1-800-899-7095

Medicare Carriers	Insurance Counseling and Information	Peer Review Organizations (PROs)	Durable Medical Equipment Regional Carriers
KANSAS			
Medicare/Blue Cross/Blue Shield of Kansas 1-800-432-3531 or (913) 232-3773	Senior Health Insurance Counseling for Kansas 1-800-860-5260	The Kansas Foundation for Medical Care 1-800-432-0407 or (913) 273-2552	CIGNA Medicare 1-800-899-7095
KENTUCKY			
AdminaStar of Kentucky 1-800-999-7608 or (502) 425-6759	Kentucky Benefits Counseling 1-800-372-2973	Health Care Excel, Inc. 1-800-288-1499	Palmetto Government Benefits Administrators 1-800-213-5452
LOUISIANA			
Louisiana Medicare Part B 1-800-462-9666 Baton Rouge: (504) 927-3490	Senior Health Insurance Information Program 1-800-259-5301	Louisiana Health Care Review, Inc. 1-800-433-4958 or (504) 926-6353	Palmetto Government Benefits Administrators 1-800-213-5452
MAINE			
National Heritage Insurance Company 1-800-492-0919	Health Insurance Counseling Program 1-800-750-5353	Northeast Health Care Quality Foundation 1-800-722-0151	United Health Care Insurance Co. 1-800-842-2052
MARYLAND			
Counties of Montgomery & Prince Georges: Exact Medicare Services 1-800-444-4606 Rest of state: Trail Blazer Enterprises 1-800-444-4606	Senior Health Insurance Counseling and Advocacy Program 1-800-243-3425	Delmarva Foundation for Medical Care 1-800-492-5811 Outside Maryland: 1-800-645-0011	AdminaStar Federal Inc. 1-800-270-2313
MASSACHUSETTS			
National Heritage Insurance Company 1-800-882-1228	Serving Health Information Needs of Elders 1-800-882-2003	Massachusetts Peer Review Organization 1-800-252-5533 or (617) 890-0011	United Health Care Insurance Co. 1-800-842-2052

Medicare Carriers	Insurance Counseling and Information	Peer Review Organizations (PROs)	Durable Medical Equipment Regional Carriers
MICHIGAN Michigan Medicare Claims In 906 area code: 1-800-562-7802 Rest of State: 1-800-482-4045 or (313) 225-8200	Medicare/Medicaid Assistance Program 1-800-803-7174	Michigan Peer Review Organization 1-800-365-5899	AdminaStar Federal Inc. 1-800-270-2313
MINNESOTA MetraHealth Medicare 1-800-352-2762 or (612) 884-7171	Health Insurance Counseling Program 1-800-333-2433	Stratis Health 1-800-444-3423 or (612) 854-3306	AdminaStar Federal Inc. 1-800-270-2313
MISSISSIPPI Metra Health 1-800-682-5417 or (601) 956-0372	Insurance Counseling and Assistance Program 1-800-948-3090	Foundation for Medical Care 1-800-844-0600 or (601) 354-0304	Palmetto Government Benefits Administrators 1-800-213-5452
MISSOURI Blue Cross/Blue Shield of Kansas Counties of : Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Claire, Saline, Vernon, and Worth: 1-800-892-5900 or (816) 561-0900 Rest of state: Medicare General American Life Insurance Company 1-800-392-3070 or (314) 843-8880	Community Leaders Assisting the Insured of Missouri 1-800-390-3330	Missouri Patient Care Review Foundation 1-800-347-1016	CIGNA Medicare 1-800-899-7095

Medicare Carriers	Insurance Counseling and Information	Peer Review Organizations (PROs)	Durable Medical Equipment Regional Carriers
MONTANA			
Blue Cross/Blue Shield of Montana 1-800-332-6146 or (406) 444-8350	Partnership for Health Insurance Information, Counseling and Assistance Program 1-800-322-2272	Mountain Pacific Quality Health Foundation 1-800-497-8232 or (406) 443-4020	CIGNA Medicare 1-800-899-7095
NEBRASKA			
Medicare Part B Blue Cross/Blue Shield of Kansas 1-800-633-1113	Health Insurance Information Counseling Assistance Program (402) 471-2201	The Sunderbruch Corp. of Nebraska 1-800-247-3004 or (402) 474-7471	CIGNA Medicare 1-800-899-7095
NEVADA			
Medicare Part B 1-800-444-4606	Medicare Insurance, Counseling and Assistance Program 1-800-307-4444	HealthInsight 1-800-748-6773 or (702) 385-9933 (702) 826-1996 (Reno)	CIGNA Medicare 1-800-899-7095
NEW HAMPSHIRE			
National Heritage Insurance Company 1-800-447-1142	Health Insurance Counseling, Education and Assistance 1-800-852-3388 or (603) 225-9000	Northeast Health Care Quality Foundation 1-800-772-0151 or (603) 749-1641	United Health Care Insurance Co. 1-800-842-2052
NEW JERSEY			
Xact Medicare Services 1-800-462-9306	Counseling on Health Insurance for Medicare Enrollees 1-800-792-8820	The PRO of New Jersey Inc. 1-800-624-4557 or (908) 238-5570	United Health Care Insurance Company 1-800-842-2052
NEW MEXICO			
Medicare Services New Mexico 1-800-423-2925 or (505) 821-3350	Health Insurance Benefits Assistance Corps 1-800-432-2080	New Mexico Medical Review Association 1-800-279-6824 or (505) 842-6236	Palmetto Government Benefits Administrators 1-800-213-5452

Medicare Carriers	Insurance Counseling and Information	Peer Review Organizations (PROs)	Durable Medical Equipment Regional Carriers
NEW YORK Empire Medicare Services Counties of Bronx, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Richmond, Rockland, Suffolk, Sullivan, Ulster and Westchester: 1-800-442-8430 or (516) 244-5100 Group Health Queens City: (212) 721-1770 BC/BS of Western N.Y. Rest of state: 1-800-252-6550 or (607) 766-6223	Health Insurance Information Counseling and Assistance Program 1-800-333-4114 In New York City: (212) 869-3850	Island Peer Review Organization, Inc. 1-800-331-7767 or (516) 326-7767	United Health Insurance Co. 1-800-842-2052
NORTH CAROLINA CIGNA Medicare 1-800-672-3071 or (910) 665-0348	Seniors' Health Insurance Information Program 1-800-443-9354	Medical Review of North Carolina 1-800-722-0468 or (919) 851-2955	Palmetto Government Benefits Administrators 1-800-213-5452
NORTH DAKOTA Blue Shield of North Dakota 1-800-247-2267 or (701) 277-2363	Senior Health Insurance Counseling 1-800-247-0560	North Dakota Health Care Review, Inc. 1-800-472-2902 or (701) 852-4231	CIGNA Medicare 1-800-899-7095
OHIO Medicare/Nationwide Mutual Insurance Co. 1-800-282-0530 or (614) 249-7157	Senior Health Insurance Information Program 1-800-686-1578	Peer Review Systems, Inc. 1-800-837-0664 or 1-800-589-7337	AdminaStar Federal Inc. 1-800-270-2313

Medicare Carriers	Insurance Counseling and Information	Peer Review Organizations (PROs)	Durable Medical Equipment Regional Carriers
OKLAHOMA			
Medicare Services Oklahoma 1-800-522-9079 or (405) 848-7711	Senior Health Insurance Counseling Program 1-800-763-2828	Oklahoma Foundation for Medical Quality 1-800-522-3414 or (405) 840-2891	Palmetto Government Benefits Administrators 1-800-213-5452
OREGON			
Medicare Part B 1-800-444-4606	SHIBA 1-800-722-4134	Oregon Medical Professional Review Org. 1-800-344-4354 or (503) 279-0100	CIGNA Medicare 1-800-899-7095
PENNSYLVANIA			
Xact Medicare Services 1-800-382-1274	APPRISE 1-800-783-7067	Keystone Peer Review Organization, Inc. 1-800-222-0771 or (717) 564-8288	United Health Care Insurance Co. 1-800-842-2052
RHODE ISLAND			
Blue Cross/Blue Shield of RI 1-800-662-5170 or (401) 861-2273	Senior Health Insurance Program 1-800-322-2880	Rhode Island Quality Partners, Inc. 1-800-662-5028	United Health Care Insurance Co. 1-800-842-2052
SOUTH CAROLINA			
Palmetto Government Benefits Administrators 1-800-868-2522 or (803) 788-3882	Insurance Counseling, Assistance, and Referral for Elders 1-800-868-9095	Carolina Medical Review 1-800-922-3089 or (803) 731-8225	Palmetto Government Benefits Administrators 1-800-213-5452
SOUTH DAKOTA			
Blue Shield of North Dakota 1-800-437-4762 or (701) 277-2363	Senior Health Information and Insurance Education Program 1-800-822-8804	South Dakota Foundation for Medical Care 1-800-658-2285 or (605) 336-3505	CIGNA Medicare 1-800-899-7095

Medicare Carriers	Insurance Counseling and Information	Peer Review Organizations (PROs)	Durable Medical Equipment Regional Carriers
TENNESSEE			
CIGNA Medicare 1-800-342-8900 or (615) 244-5650	I.C.A. Project 1-800-525-2816	Mid-South Foundation for Medical Care 1-800-489-4633	Palmetto Government Benefits Administrators 1-800-213-5452
TEXAS			
Blue Cross & Blue Shield of Texas 1-800-442-2620 or (214) 235-3433	Health Information, Counseling, and Advocacy Program 1-800-252-9240	Texas Medical Foundation 1-800-725-8315 or (512) 329-6610	Palmetto Government Benefits Administrators 1-800-213-5452
UTAH			
Blue Shield of Utah 1-800-426-3477 or (801) 481-6196	Health Insurance Information Program 1-800-439-3805	HealthInsight 1-800-274-2290	CIGNA Medicare 1-800-899-7095
VERMONT			
National Heritage Insurance Company 1-800-447-1142	Health Insurance Counseling and Assistance 1-800-642-5119	Northeast Health Care Quality Foundation 1-800-772-0151 or (603) 749-1641	United Health Care Insurance Co. 1-800-842-2052
VIRGINIA			
Xact Medicare Services Counties of: Arlington, Fairfax 1-800-233-1124 MetraHealth Rest of state 1-800-552-3423 or (804) 330-4786	Insurance Counseling Assistance Project 1-800-552-3402	Virginia Health Quality Center DC, MD, VA: 1-800-545-3814 or (804) 289-5320 Richmond: (804) 289-5397	AdminaStar Federal Inc. 1-800-270-2313

Medicare Carriers	Insurance Counseling and Information	Peer Review Organizations (PROs)	Durable Medical Equipment Regional Carriers
WASHINGTON Medicare Part B 1-800-444-4606	Statewide Health Insurance Benefits Advisors 1-800-397-4422	PRO-WEST 1-800-445-6941 or (206) 368-8272	CIGNA Medicare 1-800-899-7095
WEST VIRGINIA Nationwide Mutual Insurance Co. 1-800-848-0106 or (614) 249-7157	Senior Health Insurance Network 1-800-642-9004	West Virginia Medical Institute, Inc. 1-800-642-8686, ext. 266 Charleston: (304) 346-9864	AdminaStar Federal Inc. 1-800-270-2313
WISCONSIN Medicare/WPS 1-800-944-0051 or (608) 221-3330 TTY/TDD: 1-800-828-2837	Medigap Helpline: Elderly Benefit Specialist Program 1-800-242-1060	Wisconsin Peer Review Organization 1-800-362-2320 or (608) 274-1940	AdminaStar Federal Inc. 1-800-270-2313
WYOMING Blue Cross & Blue Shield of North Dakota 1-800-442-2371 or (307) 632-9381	Senior Health Insurance Information Program 1-800-856-4398	Mountain Pacific Quality Health Foundation 1-800-497-8232 or (406) 443-4020	CIGNA Medicare 1-800-899-7095

Medicare Carriers	Insurance Counseling and Information	Peer Review Organizations (PROs)	Durable Medical Equipment Regional Carriers
AMERICAN SAMOA Medicare Part B 1-800-444-4606	None	Mountain Pacific Quality Health Foundation 1-800-524-6550 or (808) 545-2550	CIGNA Medicare 1-800-899-7095
GUAM Medicare Part B 1-800-444-4606	None	Mountain Pacific Quality Health Foundation 1-800-524-6550 or (808) 545-2550	CIGNA Medicare 1-800-899-7095
NORTHERN MARIANA ISLANDS Medicare Part B 1-800-444-4606	None	Mountain Pacific Quality Health Foundation 1-800-524-6550 or (808) 545-2550	CIGNA Medicare 1-800-899-7095
PUERTO RICO Triple-S, Inc. in Puerto Rico: 1-800-981-7015 in San Juan Metro Area: (787) 749-4900	Programa de Informacion Conseiera Y Acceso A Medicare, Medicaid (809) 721-8590	Quality Improvement Professional Research Org. (787) 753-6705 or (787) 753-6708	Palmetto Government Benefits Administrators 1-800-213-5452
VIRGIN ISLANDS Triple-S, Inc. 1-800-474-7448	I.C.A. Program (809) 774-2991	Virgin Islands Medical Institute, Inc. (809) 778-6470	Palmetto Government Benefits Administrators 1-800-213-5452

HEALTH CARE FINANCING ADMINISTRATION REGIONAL OFFICES

States Served	Regional Office	Customer Services
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	Boston	(617) 565-1232
New York, New Jersey, Puerto Rico, Virgin Islands	New York	(212) 264-3657
Delaware, Washington D.C., Maryland, Pennsylvania, Virginia, West Virginia	Philadelphia	(215) 596-1335
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	Atlanta	(404) 331-2044
Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	Chicago	(312) 353-7180
Arkansas, Louisiana, New Mexico, Oklahoma, Texas	Dallas	(214) 767-6401
Iowa, Kansas, Missouri, Nebraska	Kansas City	(816) 426-2866
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	Denver	(303) 844-4024
Arizona, California, Guam, Hawaii, Nevada	San Francisco	(415) 744-3602
Alaska, Idaho, Oregon, Washington	Seattle	(206) 615-2354

TTY For the Hearing and Speech Impaired: 1-800-820-1202

This Publication is Available in Other Formats for the Disabled

• Audiocassette • Large Print (Text Only) • Braille
• Computer Diskette (ASCII or Wordperfect 5.0)

For single copies, please call the Medicare Hotline at 1-800-638-6833.
If you use a TTY/TDD the telphone number is 1-800-820-1202.

This publication is also on the Internet at HCFA's Web site address, **http://www.hcfa.gov**.

HCFA also publishes a number of booklets and pamphlets on specific parts of the Medicare program. You can find out more about those publications by contacting the Medicare Hotline or HCFA's Web site.

*U S Government Printing Office 1997 - 552-158

PREVENTING MEDICARE FRAUD

Every year fraud costs Medicare millions of dollars, and you pay part of those costs. You pay higher taxes and more in coinsurance and deductibles to cover these Medicare losses.

To help prevent Medicare and yourself from being ripped off, you should report all suspected instances of fraud and abuse. Whenever you receive a payment notice from Medicare, review it for errors. Make sure that neither you nor Medicare were billed for services, medical supplies, or equipment that you did not receive.

If you have any questions about the bill, call the Medicare carrier or intermediary that sent you the payment notice. The carrier's or intermediary's name, address, and telephone number will be on the payment notice.

If you believe that a health care provider is cheating or abusing the Medicare program, call the Inspector General's hotline to receive instructions on how to report suspected cases of fraud. The phone number is:

1-800-HHS-TIPS (1-800-447-8477)

TTY for the hearing and speech impaired: 1-800-377-4950

HERE ARE SOME THINGS YOU CAN DO TO PROTECT YOURSELF AGAINST HEALTH CARE FRAUD:

- Never give your Medicare or Medicaid number over the telephone or to people you do not know.
- Never let anyone convince you to contact your doctor to request a service you do not need.
- Never let anyone look at your medical records or prescription medications without your doctor's approval.
- Do not accept free medical equipment, such as wheelchairs or walkers. Only your doctor can order medical equipment for you.
- Beware of health care providers who say they are part of Medicare or any branch of the federal government, or providers who use pressure tactics to get you to accept a service or product.

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Official Business
Penalty for Private Use, $300
DO NOT FORWARD

Publication No. HCFA – 10050
Revised 1997

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration